SCHOOL DISTRICT REFERRAL
TO
REHABILITATION SERVICES FOR THE BLIND

☐ I do not wish for a referral to be made at this time.

☐ I wish for a referral to be made and I give consent to release the following information to Rehabilitation Services for the Blind:

_____ _____
Date Signature

_____ _____
Student Name Date of Birth

_____ _____
Address City, State, Zipcode

_____ _____
Home Phone Number Work Phone Number (If applicable)

_____ _____
Parent/Guardian Name County
(Not required if student is age 18+)

_____
School District Name

_____ _____
Contact Name Contact Phone Number

Directions:
1. Maintain copy of release in student's record.
2. Send referral to the attention of: Ms. Sally Howard
Rehabilitation Services for the Blind
P.O. Box 88
Jefferson City, MO 65103